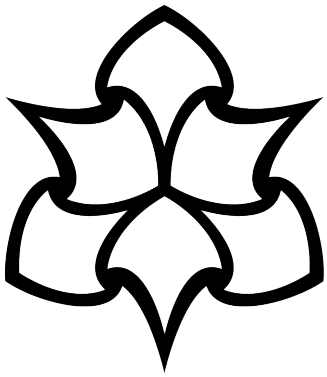

- **McLaughlin, H., Robbins, R., Banks, C., Bellamy, C. and Thackray, D. (advance access) Adult social work and high-risk domestic violence cases, *Journal of Social Work***

Adult Social Work and High-Risk Domestic Violence Cases

Abstract

Summary

This article focuses on adult social work's response in England to high-risk domestic violence cases and the role of adult social workers in Multi-Agency Risk and Assessment Conferences. (MARACs). The research was undertaken between 2013-2014 and
focused on one city in England and involved the research team attending MARACs, Interviews with 20 adult social workers, 24 MARAC attendees, 14 adult service users at time T1 (including follow up interviews after six months, T2), focus groups with IDVAs and Women's Aid and an interview with a Women's Aid service user.

Findings

The findings suggest that although adult social workers accept the need to be involved in domestic violence cases they are uncertain of what their role is and are confused with the need to operate a parallel domestic violence and adult safeguarding approach, which is further, complicated by issues of mental capacity. MARACS are identified as overburdened, under-represented meetings staffed by committed managers. However, they are in danger of becoming managerial processes neglecting the service users they are meant to protect.

Applications

The article argues for a re-engagement of adult social workers with domestic violence that has increasingly become over identified with child protection. It also raises the issue whether MARACS remain fit for purpose and whether they still represent the best possible response to multi-agency coordination and practice in domestic violence.

Keywords

Adult social work, older people, domestic violence, domestic abuse, MARACs

Introduction

This article reports on findings from a research project whose aim was to identify and assess the effectiveness of adult social care's contribution to the development of MARACs and the protection of adults facing domestic violence. The research was undertaken in one Northern city in England between 2013-2014 and involved the research team attending a MARAC, interviews with 20 adult social care staff, 24 MARAC attendees, 14 adult service users at

time T1 and follow up interviews after six months (T2) with 4 of these and focus groups with Independent Domestic Violence Advocates (IDVAs) and Women's Aid and an interview with a Women's Aid service user. IDVA's are:

> *specialist case workers who focus on working predominantly with high risk victims, those most at risk of homicide or serious harm. They work from the point of crisis and have a well-defined role underpinned by an accredited training programme. They offer intensive short to medium term support.* (Howarth, Stimpson, Barran and Robinson, 2009: 6)

The article begins by identifying the rationale for this study, clarifying terminology and identifying the role of MARACS in managing high-risk victims of domestic violence. The research methodology is then described followed by the data analysis and a discussion of the findings. The conclusions suggest that MARACs are in need of review and that adult social workers are uncertain of both their role in domestic violence and their contribution to MARACs.

Background

O'Keefe, Hills, Doyle, McCreadie et al. (2007) in a UK study of older people's prevalence rates of abuse and neglect identified older women as an area with little research evidence but prevalence rates in their study suggested that 2.6% of older women, those aged 66 years or over experienced domestic abuse or violence. Of this group, only 3% were known to adult protection services. This accounted for 227,000 older people and as our ageing population has continued to increase this number is likely to have grown since then. They also stated that this prevalence rate was in keeping with other international studies.

Lazenblatt, Devaney and Gildea (2013) reviewed the literature on older women and domestic violence and found that older women were virtually absent from the research literature and that; 'service providers and policy makers often assume that DV stops at around 50,' (Lazenblatt *et al.* 2013, p28). This is patently not the case as studies by Blood, (2004), Scott, (2008) and Lazenblatt *et al.* (2013) indicate that older women victims suffer silently, face serious barriers to accessing services and when they do access services they are often provided with inappropriate services (Beaulaurier, Self, Newman and Dunlop, 2007).

Heffernan, Blythe, and Nicolson (2014) have also identified the relationship between adult social workers and domestic violence as under researched:

> Regardless of positive strides being made in acknowledging domestic violence as a global health issue, there remains a serious gap in research exploring social care intervention in cases of domestic violence. (Heffernan et al. p711)

Peckover (2013) suggests that domestic violence has become increasingly synonymous with child protection concerns. This then makes it less likely to be viewed as an issue of concern

for adult social workers. At the same time, older women who have children may fear that the reporting of domestic violence will result in their children being removed.

Social care in England is defined by the Department of Health (2006, p.18) as:

> …the wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships.

This definition includes staff in both qualified and non-qualified roles within the statutory, voluntary, and private sectors that support vulnerable people living in the community, respite care and residential care. This also covers a range of service-user groups including people with mental health issues, people with disabilities, and older people. It should be noted that people could be in more than one group so that it is possible to be both an older person and have mental health needs. Social care work in domestic violence covers not only the adult social worker role, but also Independent Domestic Violence Advocates (IDVAs) and can range from providing practical personalised caring through to assessment and rationing of resources to managing risk, advocacy and representation. This article is particularly focused on domestic violence or domestic abuse; both terms are often interchangeable to cover the same issues. We have decided to use domestic violence as our concern is with those cases with a high risk of domestic homicide. Domestic violence, or abuse, is identified as:

> … any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. (Home Office, 2013a 3.2)

This 'incident based approach' expands the previous definition to include young people aged 16 and 17 and emphasises coercive control. There are however women who find themselves excluded from research and/or services concerned with domestic violence and Harne and Radford (2008) identified difficulties associated with women who are disabled, migrants or women living within traveller communities.

Prevalence of domestic violence

Domestic abuse and domestic violence have again become very topical in England with the highly critical, Her Majesty's Inspectorate of Constabulary (HMIC, 2014a) report, advice from NICE (2014) and the Local Government Association and Association of Director of Adult Social Services guide (LGA ADASS, 2013). Estimating the scale of domestic violence is fraught with issues of definition and data collection. Gupta (2003) notes that murders of South Asian women have been concealed as accidents whilst Harne and Radford (2008) have identified problems with the British Crime Survey data including the reluctance to name incidents as domestic violence by both the police and victims. The House of Commons Home Affairs Committee (2008) have also raised issues about 'honour–based violence' and forced marriage. The British Columbia Centre for Excellence for Women's Health (2013) has

suggested that the use of different tools to identify domestic violence results in different identification rates. However, the systematic under-reporting of domestic violence has also been identified as a European Union issue (FRA, 2014)

In 2012 the Home Office (2013b) estimated that 1.2 million women suffered domestic abuse whilst Flatley, Kershaw, Smith, Chaplin and Moon (2010) estimated 26.6% of women and 15.9% of men aged between 16-59 and had experienced one or more forms of partner abuse. In relation to older women the Home Office (2009) estimated that approximately 15% of women aged over 50 years have experienced some form of domestic violence, which can occur well into later life (WHO, 2002).

Domestic violence is gendered (Hearn and McKie, 2008), with women and girls forming the majority of victims. Though both women and men suffer abuse, women are more likely to have experienced physical injuries from abuse and repeated incidences of abuse with 2 women killed each week in England and Wales constituting 40% of all female murder victims (Home Office, 2006). It should also be noted that fewer than 1:4 people who suffer domestic violence report it to the police (Home Office, 2013b). Whilst older women share many of the same issues as women generally e.g. they were unaware of how to get practical help (Pritchard, 2000) It is also suggested older women may have different understandings of abuse, they may regard the violent behaviour as normal (Phillips, 2000) and may feel particularly ashamed if they have been accepting domestic violence from their partners for some time. They may also fear that the consequences of intervention may result in them losing their financial independence, losing their home or even being placed in a nursing homes (Women's Aid, n/d)

Multi Agency Risk Assessment Conferences (MARACS)

MARACs, are a key component of UK multi-agency practice to counter high-risk cases of domestic violence and have been defined as:

> Multi-agency meetings where statutory and voluntary agency representatives share information about high-risk victims of domestic abuse in order to produce a co-ordinated action plan to increase victim safety. (Blakeborough and Nicholas, 2011, p.1)

The first MARAC was introduced in 2003 in Cardiff and brought together 16 agencies including police, probation, local authority, health, housing, refuge and the Women's Safety Unit. MARACs represent a non-statutory co-ordinated community response to high-risk domestic violence cases which Hague and Bridge (2008, p.185) view as being "widely recognised as the best way forward" to protecting victims. MARACs aim to:

1. safeguard adult victims,
2. make links with other public protection arrangements in relation to children, perpetrators and vulnerable adults,

3. safeguard agency staff,
4. address the behaviour of the perpetrator (CAADA, 2012, p. 2).

MARACs are focussed on those considered to be the most 'high-risk' victims, that is, the top 10% of those most likely to suffer serious harm or domestic homicide. In order to identify potential MARAC cases a Co-ordinated Action Against Domestic Abuse – Domestic Abuse, Stalking and 'Honour' –Based Violence (DASH) Risk Identification Checklist (RIC) is completed (Safe Lives n.d.). This is a three-page form with 24 risk factors that asks yes/no/don't know questions. The checklist also includes an area for consideration by the referrer for other relevant information and asks whether there are reasonable grounds for referral to a MARAC. Peckover (2014,) has criticised the actuarially based DASH RIC approach as privileging actuarially based decision-making at the expense of professional judgement neglecting the complexity of these types of cases.

The LGA and ADASS (2013) also argue that the form privileges women who have children or are pregnant as there are questions about these issues leaving fewer questions for older women to reach the referral score. If high risk is identified by a referral agency, for example, the police or adult social services, the case is presented to a MARAC meeting without the victim being in attendance. In a review of MARACs Steel, Blakeborough and Nicholas (2011) provided an overview of MARACs for the Home Office. The review highlighted good working practices nationally in relation to administration and research and information sharing but also identified areas that presented challenges for MARACs, these included: identification of high risk domestic violence; representation by agencies; managing the volume of referrals and action planning. These findings also highlighted the need to balance a workable caseload against a wish to increase referrals to MARAC from a wider range of agencies.

Research Methodology

The research adopted a multi-methods case study (Cresswell, 2003) approach to a city in the North of England with above average MARAC referrals. The choice of city followed discussions with key MARAC attendees and the police who were keen to evaluate the performance of their MARAC. The higher than average referrals could be interpreted either that the city had lower thresholds or that there were other problems within the area resulting in a larger percentage of referrals. In discussion with the project's advisory panel we were advised that the methodology for assessing referral rates was currently under review and it was too early to say whether, of if, either explanation was correct.

The case study focused on just one city to allow the research team to focus in greater detail and depth on the operation of a single MARAC. Punch (2014, p.124) describes case studies as particularly useful in areas 'where our knowledge is shallow, fragmentary, incomplete or non-existent'. Whilst our knowledge of adult social workers, domestic violence and MARACs cannot be described as non-existent, it is shallow, fragmented and often over looked. The research data collection used a multi-methods approach and included all research team members attending a MARAC; interviewing twenty four agency MARAC attendees (including

some who did not, but were invited) twenty adult social care workers; focus groups with IDVAs, and practitioner's from Women's Aid. We also interviewed 14 women whose cases had been considered by a MARAC. We then attempted to re-interview these service users after six months to offer a more reflective opportunity to consider the process but although twelve women had initially agreed to be re-interviewed we were only able to contact and re-interview four of the original cohort. The research team were supported by an ex-MARAC service user who acted as a critical friend reviewing interview schedules and commenting on findings. Lastly, there was a scoping review (Robbins, McLaughlin, Banks, Bellamy and Thackray (2014)) and an analysis of the available statistical data.

Data Analysis

The data was analysed thematically using the constant comparative method (CCM) (Boeije, 2002) both within and between the various datasets. CCM requires a series of steps in which items of data were subject to internal comparison (open-coding), then comparison within each data set (axial coding) and then across data sets (triangulation). The focus was on similarities and differences within, for example between the service users or between MARAC attendees and then between the different data sets e.g. between the service users and MARAC attendees and how these helped us to understand the experience of MARAC subjects better. The differing data sets were linked to challenge previous conceptions and create new themes (Moran-Ellis et al., 2004). These data sets were then cross-matched and used to challenge the data from the other sources, such as Adult Social Care staff. Following several meetings and cycles of comparison no new insights were identified between the different data sets and it was assumed data saturation had been achieved. The key themes from the research discussed in this article refer to the MARAC process, are MARACs making a difference, the magic wand and adult social workers and MARACs.

Practical Issues

The research participants group were recruited sequentially from the start date of the research to be able to be re-contactable at the follow up interview in six months. Given the lack of demographic data collected by the MARAC it is not possible to clarify whether this group were representative of adults who were subject to MARACS, nor did the lack of recorded demographic detail allow us to consider other issues like ethnicity or disability.

Information about the research was not forwarded to the service users as this could have potentially caused problems for the service users if their abusers became aware that they were talking to researchers about their abuse. Although eighteen women agreed to this only fourteen turned up. When the researchers tried to re-contact the women, phones were no longer operating and in one case the researcher was asked to re-contact them at a specified date and time but when they did, there was no answer. Letters were not used as these again could have placed the MARAC subject under greater risk if the perpetrator were to know about the proposed contact. The follow-up interviews proved even more difficult for

although twelve interviewees agreed to be re-contacted we were only able to re-contact four and although their stories were very similar and highly informative they cannot be viewed as representative. There are potentially a number of reasons for this. The women may not have wished to be reminded of the trauma they experienced, they may have 'moved on' or that they may even have returned to live with the perpetrator or set up home with a new partner.

There were also issues in relation to children's safeguarding resulting in one interviewee being referred to children's social services for historical child sexual abuse. In this case the respondent was advised of what we needed to do and why. She was accepting of this and agreed it was what she wanted to happen The study information sheet and informed consent form, which were discussed with all participants, covered such safeguarding issues. Even so, the passing on of such information could be interpreted as a breach of confidentiality. This has implications not only for registered social workers who are also researchers, but also for all social researchers who need to be aware of the boundaries of confidentiality. Similarly, such situations need to be handled honestly and in line with the service users signed informed consent form. The Local Government Association and Association of Directors of Adult Social Services (2103) joint advice to adult social workers in relation to domestic violence also discusses that service user confidentiality cannot remain sacrosanct. In particular they highlight cases of child safeguarding or serious criminal offences where workers will be expected to refer on and advise the service user about what they are doing and why. Hopefully, this may be done in agreement, but this may on occasions not be possible.

Results

MARAC Process

Before discussing the role of adult social workers in MARAC it is important to consider the perspectives of the MARAC attendees in relation to the effectiveness of the process and the role of adult social work. Twenty-four MARAC attendees were interviewed, these included representatives of the core statutory agencies; police, health services, adult and children's social services, IDVAs, probation, 3 different housing provider representatives, and voluntary sector members like, Women's Aid, Relate and Women's Safety.

Place table 1 around here

In all cases there was only one or two interviewees per agency, and as such it would be unethical to identify each quotation by their agency as this would potentially identify the respondent.

At the start of the MARAC meeting, the chair, a member of the police will check that the previous volunteered actions had been undertaken and will then move onto the current list of cases. There is no discussion as to the effectiveness or intended and unintended consequences of the previous actions. It should also be noted that if members wish to discuss a case in greater detail they are encouraged to identify a strategy meeting outside the MARAC as one of their actions. At the outset of the research we were informed that each 'case' was allocated twelve minutes, but by the end of the research period this had been reduced to ten minutes due to the increasing volume of referrals. At the research site there was on average twenty cases per meeting to be managed. Service users are not invited and it is expected that IDVAs will have contacted the service user beforehand to advise them about what is happening. They will also contact them again after the event. It also became clear in our MARAC service user interviews that many of the respondents did not understand what a MARAC was and conflated it with the IDVA role. We were informed that the ideal MARAC attendee was a manager who was able to allocate resources on behalf of their agency and who was pro-active in volunteering resources. In fact frontline staff were to be actively discouraged:

> *Sometimes you'll get a frontline worker come along, give us a huge amount of detailed often irrelevant information and this will slow up the whole proceedings.* (MARAC statutory agency Representative)

Neither victims of serious domestic abuse nor front-line staff were welcomed at the MARAC. In contrast the MARAC attendees did identify agencies who they felt should be attending but currently were not doing so. These included children's and adult's social services representatives as their service were undergoing a restructuring resulting in a loss of previous MARAC attendees, the mental health service which regularly only attended one of the three city MARACs and a voluntary women's safety service and drugs and alcohol services. Staffing issues were the main reason for non-attendance whilst the independent women's safety organisation believed they should be in attendance but;

> *If we were to attend each MARAC we would not hit the performance targets set by our local authority funders, but yes, we should be there* (MARAC respondee from an independent agency who no longer attends)

Are MARCS making a difference?

All the MARAC respondents presented as very committed to supporting victims of domestic violence and all felt they were making a positive impact on people's lives. A key identified strength was:

> *The sharing of information is a key strength of MARAC – we don't know all the information and I've heard information I didn't know.* (MARAC statutory agency attendee)

Although there was one voice who raised the issue that:

> *If too much information becomes shared it becomes difficult to tease out the implications of the decisions needed for middle or senior managers to be able to commit resources. (*MARAC statutory agency attendee)

However, when we asked for evidence on making a difference in service user's lives the, respondents became stuck:

> *In the main the massive issue you have with any domestic violence, which I don't know if MARAC would ever sort out, it's certainly my view from working with domestic violence victims for 4 years, is we can just keep offering. But ultimately if they won't engage, if they won't come on board, you know, we can only offer, we can only try and do but ultimately it is down to the victim.* (MARAC independent agency attendee)

Where there was an answer it inevitably referred to reducing 'repeat offending'. This was highly problematic as when we discussed this further it became clear that the same victim could suffer high-risk domestic violence from the same perpetrator in an adjoining police force and the information of the previous attack would not necessarily be known; as there is no automatic check between police regions, only the local force. Also, if the same victim should be attacked again by a different perpetrator this would not be classed as repeat victimisation. Safelives (N.D.) defines a repeat MARAC case as:

> ...one which has been previously referred to a MARAC and at some point in the twelve months from the date of the last referral a further incident is identified. Retrieved from http://www.caada.org.uk/definition-repeat-marac

Safe Lives also suggests that the average repeat rates for MARACS should be between 28-40%. However, this is only known repeat rates and they acknowledge that this is unlikely to reflect the true level of repeat offences. The reliance on the reduction of repeat offences is, as we have discussed a highly problematic indicator of success. Steel et al's. (2011: ii) research noted that the "available evidence on MARAC outcomes is relatively weak," and that what is required is a more "robust evaluation". Westmarland and Kelly (2013) in their interviews with perpetrators of domestic violence undertaking a perpetrator programme and their ex/partners found a more nuanced perspective. They argued that for victims and perpetrators success is about much more than the absence of further violence and includes the ability to have respectful relationships, to live life to the full and the potential to have safe and positive parenting.

It is hard to escape the view that representatives at the local MARAC were so busy struggling with the volume of work that they were unable to stand back and identify where the impact of their work either positive or negative. This was further compounded by the lack of completed statistical data in relation to the age, ethnic grouping, disability status and sexuality of those being referred.

Given the number of cases and the time provided to each case attendees informed us that they would lose track of which case was being discussed and whether they had any information for that case.

> *And with the best will in the world, they are all merging into 1 by the time you get to about 10 or 15. You know, and I find myself saying: 'well, what are we gonna do about these children?' and then they say: 'this one hasn't got any kids'.* (MARAC statutory agency attendee)

For the vast majority of MARAC attendees MARAC attendance was seen as an add-on to their major role and that most of these did not receive supervision, or emotional support for this role, which was concerning as one respondent noted:

> *I think it has changed me as a person, I think. You know, all I hear is the horror that people do to each other and I think it has changed me as a person* (MARAC statutory agency attendee)

Her Majesty's Inspectorate of Constabulary also published their findings on the local police force's handling of domestic abuse as the research was nearing an end and concluded that:

> The force works well in partnership through the multi-agency risk assessment conferences (MARACs) where agencies come together to discuss high-risk cases and agree a coordinated response to keeping victims safe. However, we found that *consistently increasing numbers of referrals to some MARACs may mean that they become unsustainable*. (italics put in by authors, HMIC, 2014b p.8).

The HMIC reports (2014a and 2014b) nationally and locally are quite damming of the police response to domestic violence although it highlights positive work with high-risk victims. This research whilst accepting there was good evidence of a coordinated response we were however concerned about the lack of attention paid to the outcomes of this approach for service users.

The Magic Wand.

All MARAC attendees were asked; "*If you had a magic wand what would you do to make things better for MARAC subjects?"* The answers fell into three main groups. The largest group, which contained almost everyone, identified the need for 'more of the same' to make up for the reductions in services. They wanted more social services input, more IDVAs, police personnel or more temporary accommodation including hostels for those who use drugs.

This could be seen as a reaction to the austerity measures that had reduced the availability of such services. The second largest group mentioned by almost half of the respondents identified the need for domestic violence to be addressed within the school curriculum in relation to the development of healthy relationships. The third group of answers were more specific and targeted at groups who were not seen as regularly attending the MARAC but should be doing so e.g. children's and adult social services. A few respondents mentioned all three areas.

This also led onto the discussion as to whether MARAC's should remain as a voluntary service or become a statutory service like the Multi-Agency Public Protection Agency (MAPPA). MAPPA can be seen as being the reverse side of MARACs whose focus and remit is to protect the public from serious harm by sexual and/or violent offenders requiring local bodies to work together in partnership to manage the risk.

As previously noted, one of MARACs four aims was to address the behaviour of the perpetrator (CAADA, 2012: 2), however none of our respondents identified this as a major role. It could also be argued that we have a statutory response for MARAC perpetrators but only a voluntary response for the victims of the perpetrators. The vast majority of MARAC attendees felt that that the MARAC should be statutory as currently:

> *Everyone meets on an equal footing so there is no one who can command Children's Services to be there. (*MARAC independent agency attendee)

The major justification for the MARACs becoming statutory was that this would ensure attendance of all agencies, including not only children's services, but also drug and alcohol and mental health services. There were however, a small minority who felt that if MARACS became statutory they would become even more proceduralised and that the agencies would work together less effectively. However, it was a popular view that MARACs should become statutory, and then they would be able to command agency resources thus raising the profile of domestic violence services and being able to hold agencies to account.

> *The biggest thing that could happen to MARAC is that it become statutory, that's why I think that sometimes it doesn't get the support it deserves. If it was statutory it would sharpen up people's involvement.* (MARAC statutory agency attendee)

Adult Social Workers and MARACS

In total 20 staff were interviewed from across the local authority's adult social work workforce, including a senior manager, team manager, senior practitioner, adult safeguarding co-ordinator and sixteen adult social workers. All were registered social workers. Following a recent restructuring and revised lines of management accountability, managers were uncertain what role adult social work had in responding to domestic violence:

> *Domestic abuse is everyone's business'….I know it is very important that we're all around the table, but not all clear why we are there..I am embarrassed by department's response, (Adult services senior manager)*

Amongst the adult social work practitioners, there was a wide variation in understanding of domestic violence and MARAC. As one adult social worker said "isn't that a police role?" Whilst another worker who was more aware of MARAC stated:

> *I would mentally consider the MARAC process and the RIC and check some of the questions and would consider whether it would make a MARAC case.* (Adult social worker 10)

Adult social workers identified a wide range of training on domestic violence with others claiming they had had none. For others their only training had occurred as part of their qualifying course, whilst some others had completed a local authority two-hour online course and a small minority who had completed further training on domestic violence. All the adult social care workers, irrespective of previous training, agreed that further training in domestic violence interventions would be beneficial. One adult's manager stated:

> *There have been strong pushes towards people attending the training. There have been problems with take up until recently and courses are cancelled. There are now more clear management directions that the training is mandatory and you can only go for so long without attending before someone picks you up.* (Adult services manager).

This wide variation of experience and knowledge was also evident in how adult social workers considered domestic violence. If domestic violence is reinterpreted as a safeguarding issue adult social workers appeared to feel on firmer ground. Adult social workers appeared to struggle with issues of criminal offences and the nature of MARAC referred cases whereby a number of adult social care workers indicated that if the MARAC referred person did not want anything to happen, this was acceptable, as long as they were deemed to have mental capacity:

> *If a customer has capacity, knows the consequences of their actions, and doesn't consent to further action then you can't do anything. Can't force the issue, can only advise and give what the options are.* (Adult social worker 3)

This raises a very serious challenge for adult social work and how we assess mental capacity. MARAC subjects are identified as the top 10% of those at highest risk of serious harm or domestic homicide, it then becomes problematic as to whether someone can be seen to have provided their informed consent to their potential murder? In DL vs A Local Authority and Others (2012) the Court of Appeal upheld that inherent jurisdiction within the Mental Capacity Act (2005) permitted local authorities and others to instigate High Court proceeding for:

> …enhancing or liberating the autonomy of a vulnerable adult whose autonomy has been compromised by a reason other than mental incapacity because they are … (a) under constraint; or (b) subject to coercion or undue influence; or (c) for some other reason deprived of the capacity to make the relevant decision or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent". (DL vs A Local Authority and Others, 2012, para 54).

The DL case involved DL's parents who were not deemed to normally lack mental capacity but were temporally unable to do so as a result of the undue influence, duress and intimidation that DL brought to bear upon them. Such an occurrence has similarities to some high-risk domestic violence cases and it is worth noting that one of the common themes from the MARAC subject interviews was a sense of 'loss of control'. For about half of those interviewed there was a general view that they were relieved someone else was making decisions for them as they felt they were no longer able to act for themselves. For the other half, they wanted to be part of the decision-making process and were unhappy that others were making decisions about them, without them. It could be argued that in these cases the MARAC process further abuses the service user by undermining their self-esteem and self-worth that is already likely to be at a low level. The responses of the MARAC subjects would suggest that this is a complex area and just assuming that people are making informed choices is fraught with difficulty and requires more discussion, debate and training.

Another issue for many adult social workers was that when cases were referred to MARAC they indicated they rarely found out what had happened after the MARAC meeting. Changes within the local authority to promote co-ordination and consistency where planned with the identification of representatives from adults services to attend MARACs. Whilst this was seen as a move forward there was also a concern expressed that as the representation will be shared by a number of staff this may inhibit the development of expertise and personal relationships and run the risk of a lack of consistency in practice. All interviewees concluded that there is a major role for adult social care services within the MARAC processes but adult social care managers need to work with other agencies and staff to articulate and identify what this should be.

Limitations of the Research

There are limitations to this research particularly in that it is focussed on only one area and the evidence presented would be more representative if the research could be replicated in other areas of the country with differing population sizes, police forces, rural as well as urban settings and differing governance arrangements. The Northern research city's police force where the research was based covered a number of other local authorities that managed MARAC processes similarly. Whilst it is not possible to generalise from case

studies this is not to say they cannot add to our knowledge or highlight key issues for future consideration or research in areas where our knowledge has been incomplete and/or lacking in depth (Punch, 2014). These results should be considered as tentative but they do support the previous concerns of Steel *et al.* (2009*)* and many of those from HMIC (2014) and LGA ADASS (2013). Lastly, having presented this research in different parts of the UK the results have resonated with those audiences suggesting that the issues identified go beyond the research site and are worthy of wider consideration.

Discussion

The substantive findings suggest that MARACs are a misnomer. In the research site MARACS considered on average 20+ cases per meeting for 10 minutes per case and it is highly questionable whether in such a short time they can; safeguard adult victims, make links with other public protection arrangements, safeguard staff and address the behaviour of the perpetrator. The meetings the research team attended were not conferences in that unlike the research site's agency child protection conferences which highlight the need to; '.. bring together and analyse'…'consider the evidence'.. and '.. to decide what further action is required'. MARACs are unable to provide the time for this level of multi-agency holistic analysis, synthesis of information, discussion and decisions on future interventions. Instead, they have become a managerialist response to a personal problem in a system that is in danger of becoming so overloaded it does not have time to reflect on its own effectiveness.

MARAC meetings require managers who can allocate resources not practitioners with experience of the case. Those experiencing the violence are excluded. MARAC members admit they are unable to concentrate effectively for all the cases they hear and MARACS do not have a system for reviewing the effectiveness of their actions or the outcomes of their involvement. MARACs are not conferences, like child protection conferences, they do not encourage a holistic risk assessment of a service user's situation prior to the development of an action plan. MARACs are much more immediate in dealing with the current risk and should consider whether they should be renamed as MAISRRM – Multi-Agency Information Sharing and Risk Reduction Meetings or even more radically become a conference! Such change though would require either an increase in resources or a change in thresholds to reduce the demand or both.

MARACS can only be as effective as the people who attend them, share information and volunteer resources. It could also be argued that if the subject of the MARAC is not even given the opportunity to attend in person the conference is missing out on key information and that any plan of action is less likely to be successful if it does not have the ownership of the plan's subject. There therefore needs to be more studies engaging longer term with MARAC service users, particularly older women, to be able to learn from their experience as

to how the system could be improved and to examine ways of providing access to services beyond the emergency period.

MARAC attendees were very committed to their work and attendance was often seen as an add-on to a member's workload. This was concerning as they were rarely provided with supervision to help them cope with the harrowing information they would hear presented at each meeting.

The research team would support the MARAC interviewees who wanted MARACs to be on a statutory footing like MAPPA's and child protection conferences. This would raise the profile of domestic violence work and make it more likely that key agencies would turn up, or could be held to account if they did not. However there is one major proviso, we first need to revisit the purpose of MARACs and question whether the current processes are able to achieve these aims with clearly agreed national outcome measures. They should also consider whether they should be more inclusive where service users wish to be involved in the MARAC. As Sheldon and Chivers (2000: 2) have suggested:

> It is perfectly possible for good hearted, well-meaning, reasonably clever, appropriately qualified, hardworking staff, employing the most contemporary approaches available to them to make no difference at all to or even on occasion to worsen the condition of those whom they seek to assist.

There was also a clearly defined need for domestic violence training to be part of the mandatory training for all adult social workers if they are to work effectively with adult domestic violence victims and to be able to operate within the local MARAC processes. Senior managers have a responsibility to take a lead on this and to ensure that adult safeguarding and domestic violence are parallel processes as recommended by the LGA and ADASSS (20013) or to develop a single alternative process with inter-agency support.

Conclusions

The research set out to identify and assess the effectiveness of UK adult social care's contribution to the development of MARACs and the protection of adults facing domestic violence. However, as can be seen from above the research has identified major concerns as to the operation of MARACS and their contribution to safeguarding, whether this is adults or children. These concerns were similar to those identified by Steel *et al.* (2011) of representation, volume and action planning. They also raised issues as to MARAC effectiveness and questions whether MARACS are in danger of becoming unsustainable (HMIC, 2014 and Steel, 2011). It is time for us to consider whether MARACs still represent the best possible response to multi-agency coordination information sharing and planning in relation to domestic violence. This is of concern as MARACs are now being rolled out in other countries e.g. Australia. It was also clear that adult services, in the research area, were

not delivering safe care for adults facing high-risk domestic violence, and did not necessarily see domestic violence as an adult social work issue. Mandatory post qualifying training is essential to help address the skills and knowledge deficit. Just as importantly there is a need for senior managers in adult social work services to unpick the confusion between adult safeguarding and domestic violence and identify a strategy for addressing adult social workers contribution to identifying and assessing domestic violence whilst also clarifying their contribution to supporting the victims and perpetrators of domestic violence. Lastly, we also need to find mechanisms to ensure that the service user can, if they desire, become more involved in the process which primarily exists to protect them.

Research Ethics

The study received ethical permission from the National Institute of Social Care and Health Research 12/WA/0267. Issues of particular ethical concern included access to service users as soon after their experience of the MARAC as possible without our contact being a further abuse of the service users. The local IDVA service agreed to act as research gatekeepers and approach 'suitable' MARAC service-users on our behalf. The length of time after a MARAC varied between the MARAC subjects, but when the IDVAs considered it would not be abusive they advised the subject of the research and asked if they would speak to us of their experience. Following this we contacted the potential interviewee within a couple of days to discuss the research and arrange a mutually convenient safe venue and date and time for the interview. At the interview the information sheet was again discussed and an informed consent form completed before any interview was conducted.

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Table 1

MARAC interviewees by agency

MARAC Agency (Statutory)	**No.**	**MARAC Agency (Voluntary)**	**No.**
Police (Chair)	1	Women's Aid	1
Police (MARAC specialist)	2	Relate	1
Social Services (Adult)	2	Victim Support	1
Social Services (Children)	1	Women's Safety Service	1
Social Services specialist	1	Connexions	1
IDVA	2	**Total**	**5**
Probation	1		
Drugs service	1	Housing (Independent providers	
Fire Brigade	1	**Independent providers**	3
Health	2		
Mental Health Service	1		
Community Alcohol Team	1	**Overall Total = Statutory+**	
Total	**16**	**Voluntary + Independent**	**24**